FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028712

Facility Name: BRADLEY ROYALE

Address: 650 NORTH KINZIE AVENUE (Number) BRADLEY (City) 60915 (Zip Code)

County: KANKAKEE

Telephone Number: 815-933-1666 **Fax #** ( )

IDPA ID Number: 36-3312420

Date of Initial License for Current Owners: 07/16/1984

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DR. ARGYROIS VASSILIOU **Telephone Number:** 815-933-1666

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31//2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) DR. ARGYROIS VASSILIOU

(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) CHARLES R. BURKE, CPA, PARTNER

(Firm Name & Address) BURKE, MONTAGUE & ASSOCIATES LLC, 253 W. BROADWAY, BRADLEY, IL 60915

(Telephone) 815-933-5641 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	173	25		198	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	28,809	9,734		38,543	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,982	9,759		38,741	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.30%

D. How many bed-hold days during this year were paid by the Department?
384 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/16/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/16/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number BRADLEY ROYALE # 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	194,337	222	6,924	201,483		201,483		201,483			1
2	Food Purchase		220,449		220,449		220,449		220,449			2
3	Housekeeping	140,874	26,966		167,840		167,840		167,840			3
4	Laundry	46,877			46,877		46,877		46,877			4
5	Heat and Other Utilities			125,650	125,650		125,650		125,650			5
6	Maintenance	36,780	5,187	27,858	69,825		69,825		69,825			6
7	Other (specify):*											7
8	**TOTAL General Services**	418,868	252,824	160,432	832,124		832,124		832,124			8
	B. Health Care and Programs											
9	Medical Director			4,020	4,020		4,020		4,020			9
10	Nursing and Medical Records	984,669	110,460	3,005	1,098,134		1,098,134		1,098,134			10
10a	Therapy			10,961	10,961		10,961		10,961			10a
11	Activities	78,352	472	795	79,619		79,619		79,619			11
12	Social Services	42,661		63	42,724		42,724		42,724			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,105,682	110,932	18,844	1,235,458		1,235,458		1,235,458			16
	C. General Administration											
17	Administrative	196,300	3,660	275	200,235		200,235		200,235			17
18	Directors Fees											18
19	Professional Services			12,465	12,465		12,465		12,465			19
20	Dues, Fees, Subscriptions & Promotions			8,190	8,190	(1,340)	6,850	(425)	6,425			20
21	Clerical & General Office Expenses	64,220	14,984	32,272	111,476		111,476	(1,434)	110,042			21
22	Employee Benefits & Payroll Taxes			310,773	310,773		310,773		310,773			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,118	1,118	1,340	2,458	(1,340)	1,118			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,672	98,672		98,672		98,672			26
27	Other (specify):*											27
28	**TOTAL General Administration**	260,520	18,644	463,765	742,929		742,929	(3,199)	739,730			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,785,070	382,400	643,041	2,810,511		2,810,511	(3,199)	2,807,312			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRADLEY ROYALE #0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,949	12,949		12,949	12,715	25,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,371	21,371		21,371		21,371			32
33	Real Estate Taxes			48,414	48,414		48,414		48,414			33
34	Rent-Facility & Grounds			717,221	717,221		717,221		717,221			34
35	Rent-Equipment & Vehicles			1,049	1,049		1,049		1,049			35
36	Other (specify):*			45,000	45,000		45,000	(45,000)				36
37	**TOTAL Ownership**			846,004	846,004		846,004	(32,285)	813,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,962	62,962		62,962		62,962			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			62,962	62,962		62,962		62,962			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,785,070	382,400	1,552,007	3,719,477		3,719,477	(35,484)	3,683,993			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,715	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(634)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(45,000)	36		18
19	Entertainment	(1,340)	24		19
20	Contributions	(800)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(425)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,484)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (35,484)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRADLEY ROYALE

ID# 0028712

Report Period Beginning: 01/01/2005

Ending: 12/31//2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BRADLEY ROYALE # 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(425)	0	0	0	0	0	0	0	0	0	0	(425)	20
21	Clerical & General Office Expenses	(1,434)	0	0	0	0	0	0	0	0	0	0	(1,434)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,340)	0	0	0	0	0	0	0	0	0	0	(1,340)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,199)	0	0	0	0	0	0	0	0	0	0	(3,199)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,199)	0	0	0	0	0	0	0	0	0	0	(3,199)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BRADLEY ROYALE **#** 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	12,715	0	0	0	0	0	0	0	0	0	0	12,715	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(45,000)	0	0	0	0	0	0	0	0	0	0	(45,000)	36
37	**TOTAL Ownership**	(32,285)	0	0	0	0	0	0	0	0	0	0	(32,285)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,484)	0	0	0	0	0	0	0	0	0	0	(35,484)	45

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARGYRIOS VASSILIOU	26.00					
HELEN VASSILIOU	26.00					
PENNY VARNAVAS	24.00					
GEORGE VASSILIOU	24.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARGYRIOS VASSILIOU	PRESIDENT	MANAGEMENT	26.00	NONE	40	100.00	SALARY	$ 10,400	17-1	1
2	HELEN VASSILIOU	VICE-PRESIDENT	ACTIVITIES	26.00	NONE	40	100.00	SALARY	16,900	11 1	2
3	DINO VARNAVAS		ADMINISTRATOR		NONE	40	100.00	SALARY	85,800	17-1	3
4	PENNY VARNAVAS		MANAGEMENT	24.00	NONE	40	100.00	SALARY	100,100	17-1	4
5	GEORGE VASSILIOU		FOOD SUPERV.	24.00	NONE	40	100.00	SALARY	59,800	1 1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 273,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BRADLEY ROYALE # 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 50,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 48,414	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,586)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,414	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	49,470	8
	2001	48,825	9
	2002	49,212	10
	2003	49,212	11
	2004	49,212	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRADLEY ROYALE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0028712

CONTACT PERSON REGARDING THIS REPORT ARGYRIOS VASSILIOU

TELEPHONE 815-933-1666 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-21-300-04	TRACT IN EH SWQ EX ROW	$ 48,414.24	$ 48,414.24
2.		BAL 4.53 AC	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,414.24	$ 48,414.24

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,063 B. General Construction Type: Exterior ONE-LEVEL Frame BRICK Number of Stories ONE

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	AIR CONDITIONERS			Jul-84	12,257		10			12,257	10
11	FRONT DESK			Jan-85	900		10			900	11
12	CLOSETS			Jan-85	1,289		10			1,289	12
13	DOOR LOCKS			Mar-85	535		10			535	13
14	FIRE SAFETY			Jun-85	4,939		10			4,939	14
15	PATIO			May-85	1,508		20	54	54	1,508	15
16	LANDSCAPING			May-85	560		10			560	16
17	CARPET			Dec-85	443		5			443	17
18	MINIBLINDS			Jun-85	666		5			666	18
19	LANDSCAPING			May-85	1,791		10			1,791	19
20	ELECTRICAL LIGHTS			Aug-85	2,152		10			2,152	20
21	CARPET & WINDOW COVERINGS			Mar-87	6,915		5			6,915	21
22	HEATER			Mar-87	3,547		20	177	177	3,547	22
23	PATIOS			Aug-93	8,760		20	438	438	8,760	23
24	LANDSCAPING			Mar-94	3,985		10			3,985	24
25	ROOF REPAIRS			Apr-94	30,200	774	40	755	(19)	9,066	25
26	SIGN			May-94	700		10			700	26
27	PARKING LOT			Jul-94	22,781	1,016	20	1,139	123	14,142	27
28	PARKING BLOCKS			Aug-94	514		7			514	28
29	ROOF REPAIRS - DOME			Aug-94	2,500	64	40	62	(2)	729	29
30	ROOF REPAIRS			Mar-95	1,600	41	40	40	(1)	443	30
31	LANDSCAPING			Apr-95	500	16	10	17	1	500	31
32	LANDSCAPING			Apr-95	6,269	205	10	209	4	6,269	32
33	GAS METER RELOCATION			May-95	1,948		10	65	65	1,948	33
34	LANDSCAPING			May-95	1,579	52	10	53	1	1,579	34
35	LANDSCAPING			Jul-95	500	16	10	25	9	500	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	Sep-95	$ 757	$	10	$ 51	$ 51	$ 757	37
38	BATHROOM REMODELING	Sep-95	3,443	88	40	86	(2)	909	38
39	BATHROOM REMODELING	Oct-95	2,459	65	40	64	(1)	667	39
40	LANDSCAPING	Oct-95	500	16	10	37	21	500	40
41	ELECTRICAL WORK	Oct-95	3,265	84	40	82	(2)	855	41
42	BATHROOM REMODELING	Oct-95	2,461	63	40	62	(1)	644	42
43	LANDSCAPING	Oct-95	3,101	102	10	232	130	3,101	43
44	WINDOW COVERINGS	Mar-95	6,127		5	102	102	6,127	44
45	BATHROOM REMODELING	Nov-95	2,214	57	40	55	(2)	575	45
46	LANDSCAPING	Jun-95	2,206	72	10	92	20	2,206	46
47	LANDSCAPING	Dec-95	739	24	10	68	44	739	47
48	FLOWER BOXES	Jan-95	625		10	62	62	625	48
49	WINDOW BLINDS	Dec-96	2,071		10	207	207	2,071	49
50	HAND RAILS	Jan-96	4,015		10	401	401	4,015	50
51	NURSE CALL SYSTEM	Jan-96	31,548		10	3,146	3,146	31,458	51
52	NURSE CALL SYSTEM	Feb-96	750		10	75	75	750	52
53	WINDOW BLINDS	Feb-96	1,917		10	192	192	1,917	53
54	FLOWER BOXES	Mar-96	1,100		10	110	110	1,100	54
55	LOCKERS	Mar-96	2,877		10	288	288	2,877	55
56	LANDSCAPING	May-96	725	48	10	72	24	701	56
57	LANDSCAPING	Mar-96	3,261	214	10	326	112	3,155	57
58	WALL TILE	Mar-96	978	25	40	24	(1)	246	58
59	COUNTER	May-96	2,750		10	275	275	2,750	59
60	LANDSCAPING	Jun-96	940	62	10	94	32	909	60
61	ELECTRICAL WORK	Mar-96	12,351	317	40	309	(8)	3,101	61
62	LANDSCAPING	Jul-96	2,738	180	10	274	94	2,649	62
63	WINDOW BLINDS	Mar-96	2,590		10	259	259	2,590	63
64	PRE 1985 ITEMS		34,873		5			34,873	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 252,719	$ 3,601		$ 10,079	$ 6,478	$ 199,504	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 252,719	$ 3,601		$ 10,079	$ 6,478	$ 199,504	1
2	ROOF REPAIRS	Sep-96	13,066	335	40	327	(8)	3,113	2
3	FLOOR TILE	Mar-96	2,200	56	40	55	(1)	552	3
4	ADDITION - RELATED PARTY	Apr-96	1,194,410		40				4
5	ROOF REPAIRS	Jan-97	1,310	34	10	33	(1)	301	5
6	ROOF REPAIRS	Feb-97	1,000	26	10	25	(1)	228	6
7	LANDSCAPING	Mar-97	3,575	234	10	357	123	3,223	7
8	GALAXY PAINTING	Jul-99	1,800	159	10	180	21	1,700	8
9	GALAXY PAINTING	Nov-99	1,080	94	10	108	14	997	9
10	LANDSCAPING	Nov-99	6,996	459	10	700	241	5,220	10
11	ELECTRIC DOOR CLOSER	Mar-00	2,520	220	10	252	32	2,272	11
12	CARPET	Mar-00	3,000	41	10	300	259	3,000	12
13	ADDITION - RELATED PARTY	1-Jun	454,845		40				13
14	BOILER & HOT WATER HEATER	Nov-00	52,040	2,918	20	2,810	(108)	19,987	14
15	ICE MACHINE	3-Sep	1,499	131	10	150	19	1,171	15
16	WASHER/DRYERS	4-Apr	1,298	159	10	130	(29)	901	16
17	REFRIGERATOR/FREEZER	4-Jun	738	91	10	74	(17)	512	17
18	DRYER CHAIRS	4-Oct	622	76	10	62	(14)	432	18
19	AIR COMPRESSOR	4-Oct	306	38	10	31	(7)	212	19
20	WASHER/DRYERS	4-Jun	20,000	2,449	10	2,000	(449)	13,877	20
21	COMPUTER	5-Feb	2,069	414	5	379	(35)	414	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,017,093	$ 11,535		$ 18,052	$ 6,517	$ 257,616	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 150,467	$ 1,414	$ 7,612	$ 6,198		$ 149,250	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 150,467	$ 1,414	$ 7,612	$ 6,198		$ 149,250	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,167,560	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,949	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,664	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,715	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 406,866	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1963	98		$ 390,742			3
4	Additions	1996	7		218,035			4
5		2000	10		108,444			5
6								6
7	TOTAL		115		$ 717,221 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning 06/18/1984
Ending 12/31/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 925,000
13.	12/31/2007	$ 950,000
14.	12/31/2008	$ 975,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BRADLEY ROYALE # 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31//2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,700	$	1
2	Cash-Patient Deposits	2,743		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	476,350		3
4	Supply Inventory (priced at COST)	32,500		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 513,293	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	289,266		15
16	Equipment, at Historical Cost	229,038		16
17	Accumulated Depreciation (book methods)	(406,866)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 111,438	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 624,731	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 88,823	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	64,108		29
30	Accrued Salaries Payable	39,816		30
31	Accrued Taxes Payable (excluding real estate taxes)	208,427		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation	54,814		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 505,988	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,938		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SHAREHOLDER LOANS	575,369		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 586,307	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,092,295	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (467,564)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 624,731	$	48

***(See instructions.)**

Facility Name & ID Number BRADLEY ROYALE # 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (393,774)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (393,774)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(73,790)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (73,790)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (467,564)	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,650,471	1
2	Discounts and Allowances for all Levels	(4,784)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,645,687	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,645,687	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	832,124	31
32	Health Care	1,235,458	32
33	General Administration	742,929	33
	B. Capital Expense		
34	Ownership	846,004	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	62,962	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,719,477	40
41	**Income before Income Taxes (line 30 minus line 40)****	(73,790)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (73,790)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,160	4,160	$ 62,030	$ 14.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,664	12,707	261,228	20.56	3
4	Licensed Practical Nurses	7,708	7,629	124,440	16.31	4
5	CNAs & Orderlies	63,368	63,267	536,969	8.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,470	1,470	14,700	10.00	9
10	Activity Assistants	6,334	6,280	63,653	10.14	10
11	Social Service Workers	4,018	4,022	42,660	10.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	60,957	29.31	13
14	Head Cook	6,761	6,767	77,911	11.51	14
15	Cook Helpers/Assistants					15
16	Dishwashers	6,911	6,893	55,470	8.05	16
17	Maintenance Workers	3,157	3,162	36,780	11.63	17
18	Housekeepers	18,947	18,948	140,874	7.43	18
19	Laundry	6,048	6,064	46,878	7.73	19
20	Administrator	2,080	2,080	85,800	41.25	20
21	Assistant Administrator					21
22	Other Administrative	4,160	4,160	110,500	26.56	22
23	Office Manager	2,249	2,247	26,720	11.89	23
24	Clerical	4,548	4,585	37,500	8.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,663	156,521	$ 1,785,070 *	$ 11.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DINO VARNAVAS	ADMINISTRATION	NONE	$ 85,800
PENNY VARNAVAS	ADMINISTRATION	24.00	100,100
ARGYRIOUS VASSILIOU	ADMINISTRATION	26.00	10,400
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 196,300

B. Administrative - Other

Description	Amount
SEC OF STATE	$ 275
TOTAL (agree to Schedule V, line 17, col. 3)	$ 275
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BURKE MONTAGUE	ACCOUNTING	$ 11,265
ELLIOT & McCLURE	LEGAL	1,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,465

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,755
Unemployment Compensation Insurance	18,065
FICA Taxes	135,304
Employee Health Insurance	66,701
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE PHYSICALS	440
EMPLOYEE LIFE INSURANCE	33,508
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,773

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,190
Advertising: Employee Recruitment	3,341
Health Care Worker Background Check	644
(Indicate # of checks performed)	
DUES	
LICENSE	250
DIRECTORY - ADVERTISING	425
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(425)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,425

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MEALS & ENTERTAINMENT	1,340
Seminar Expense	1,118
Entertainment Expense	(1,340)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,118

**See instructions.

Facility Name & ID Number BRADLEY ROYALE # 0028712 Report Period Beginning: 01/01/2005 Ending: 12/31//2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING		$		$ 11	$	$	$	$	$	$	$	$
2	PAINTING				55								
3	PAINTING				94								
4	PAINTING				45								
5	PAINTING				25								
6	PAINTING				58								
7	PAINTING				44								
8	PAINTING				58								
9	PAINTING				205								
10	PAINTING				1,491	1,491							
11	PAINTING				425	35							
12	PAINTING				851	284							
13	PAINTING				834	695							
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$ 4,196	$ 2,505	$	$	$	$	$	$	$

Facility Name & ID Number BRADLEY ROYALE # 0028712 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31//2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **58,352** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **62,962**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.